



# State of Connecticut Office of Health Care Access CON Determination Form Form 2020

All persons who are requesting a determination as to whether a CON is required for a proposed project must complete this form. Completed forms should be submitted to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

## SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name		
Doing Business As		
Name of Parent Corporation		
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail		
Petitioner type (e.g., P for profit and NP for Not for Profit)		
Name of Contact person, including title		
Contact person's street mailing address		
Contact person's phone, fax and e-mail address		

**SECTION II. GENERAL PROPOSAL INFORMATION**

a. Proposal/Project Title:

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b. Location of proposal (Town including street address):

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c. List all the municipalities this project is intended to serve:

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d. Estimated starting date for the project:

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e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in all the boxes that apply)

E   P

Acute Care Hospital  
Behavioral Health Provider  
Hospital Affiliate

E   P

Imaging Center  
Ambulatory Surgery Center  
Other specify):

E   P

Cancer Center  
Primary Care Clinic

**SECTION III. EXPENDITURE INFORMATION**

a. Estimated Total Capital Expenditure/Cost:

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

New Construction/Renovations	
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
<b>Total Capital Expenditure</b>	
Fair Market Value of Leased Equipment	

<b>Total Capital Cost</b>	
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**Major Medical and/or imaging equipment acquisition:**

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide copy of contract with vendor for medical equipment.

## c. Type of financing or funding source:

Operating Funds	Lease Financing	Conventional Loan
Charitable Contributions	CHEFA Financing	Grant Funding
Funded Depreciation	Other (specify):	

**SECTION IV. PROPOSAL DESCRIPTION**

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Will you be charging a facility fee?
4. Who is the current population served and who is the target population to be served?
5. Who will be providing the service?
6. Who are the payers of this service?

**SECTION V. AFFIDAVIT**

Applicant: \_\_\_\_\_

Project Title: \_\_\_\_\_

I, \_\_\_\_\_,  
(Name) (Position – CEO or CFO)

of \_\_\_\_\_ being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that \_\_\_\_\_ complies with the appropriate  
(Facility Name)  
and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Subscribed and sworn to before me on \_\_\_\_\_

\_\_\_\_\_  
Notary Public/Commissioner of Superior Court

My commission expires: \_\_\_\_\_